

STATE OF ILLINOIS

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Facility Name & ID Number Fair Havens Christian Home# 0018143 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>161</u>	Skilled (SNF)	<u>161</u>	<u>58,765</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>161</u>	TOTALS	<u>161</u>	<u>58,765</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,366</u>	<u>10,991</u>	<u>8,208</u>	<u>39,565</u>	8
9	SNF/PED					9
10	ICF	<u>8,931</u>	<u>5,384</u>		<u>14,315</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,297</u>	<u>16,375</u>	<u>8,208</u>	<u>53,880</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.69%

D. How many bed-hold days during this year were paid by Public Aid?

673 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 12/12/1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 161 and days of care provided 8,208Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number

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0018143

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	258,256	38,024	16,852	313,132		313,132		313,132		1
2	Food Purchase		312,012		312,012		312,012	(3,537)	308,475		2
3	Housekeeping	262,367	51,846		314,213		314,213		314,213		3
4	Laundry										4
5	Heat and Other Utilities			141,083	141,083		141,083	(354)	140,729		5
6	Maintenance	68,931	30,189	48,413	147,533		147,533	13,767	161,300		6
7	Other (specify):*										7
8	TOTAL General Services	589,554	432,071	206,348	1,227,973		1,227,973	9,876	1,237,849		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,263,888	313,864	40,835	2,618,587		2,618,587		2,618,587		10
10a	Therapy			467,427	467,427		467,427		467,427		10a
11	Activities	34,001			34,001		34,001		34,001		11
12	Social Services	133,010	6,473	6,556	146,039		146,039		146,039		12
13	Nurse Aide Training										13
14	Program Transportation			1,929	1,929		1,929		1,929		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,430,899	320,337	534,747	3,285,983		3,285,983		3,285,983		16
	C. General Administration										
17	Administrative	232,723	1,868	396,180	630,771		630,771	(302,990)	327,781		17
18	Directors Fees										18
19	Professional Services			37,557	37,557		37,557	11,190	48,747		19
20	Dues, Fees, Subscriptions & Promotions			58,143	58,143		58,143	(25,187)	32,956		20
21	Clerical & General Office Expenses	170,148	19,225	240,267	429,640		429,640	(45,241)	384,399		21
22	Employee Benefits & Payroll Taxes			650,720	650,720		650,720	36,401	687,121		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,469	17,469		17,469	15,266	32,735		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			145,932	145,932		145,932	1,477	147,409		26
27	Other (specify):*										27
28	TOTAL General Administration	402,871	21,093	1,546,268	1,970,232		1,970,232	(309,084)	1,661,148		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,423,324	773,501	2,287,363	6,484,188		6,484,188	(299,208)	6,184,980		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			198,378	198,378	(195)	198,183	45,086	243,269			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,659	21,659		21,659	(13,923)	7,736			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Financing Fee			432	432		432		432			36
37	TOTAL Ownership			220,469	220,469	(195)	220,274	31,163	251,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			36,238	36,238		36,238		36,238			39
40	Barber and Beauty Shops	25,956	1,182		27,138		27,138		27,138			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,390	88,390		88,390		88,390			42
43	Other (specify):* Apt/Cong			420,809	420,809	195	421,004		421,004			43
44	TOTAL Special Cost Centers	25,956	1,182	545,437	572,575	195	572,770		572,770			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,449,280	774,683	3,053,269	7,277,232		7,277,232	(268,045)	7,009,187			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,537)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,773)	5		5
6	Rented Facility Space	(2,250)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,842	30		9
10	Interest and Other Investment Income	(44,589)	32		10
11	Discounts, Allowances, Rebates & Refunds	(941)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,172)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached 5A	5,243			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (198,177)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(69,868)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (69,868)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (268,045)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Vending Income	\$ (989)	17 1
2	Activity Expense	8	17 2
3	Increase in Cash Value of Life Insurance	(278)	17 3
4	Exempt Interest Income on Restricted Investments	30,666	32 4
5	Loss on Equipment Disposal	1,023	17 5
6	Marketing	(25,187)	20 6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	5,243	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fair Havens Christian Home

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,537)	0	0	0	0	0	0	0	0	0	0	(3,537)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(13,023)	12,669	0	0	0	0	0	0	0	0	0	(354)	5
6	Maintenance	0	13,767	0	0	0	0	0	0	0	0	0	13,767	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,560)	26,436	0	0	0	0	0	0	0	0	0	9,876	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(236)	(302,754)	0	0	0	0	0	0	0	0	0	(302,990)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,190	0	0	0	0	0	0	0	0	0	11,190	19
20	Fees, Subscriptions & Promotions	(25,187)	0	0	0	0	0	0	0	0	0	0	(25,187)	20
21	Clerical & General Office Expenses	(165,113)	119,872	0	0	0	0	0	0	0	0	0	(45,241)	21
22	Employee Benefits & Payroll Taxes	0	36,401	0	0	0	0	0	0	0	0	0	36,401	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	15,266	0	0	0	0	0	0	0	0	0	15,266	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,477	0	0	0	0	0	0	0	0	0	1,477	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(190,536)	(118,548)	0	0	0	0	0	0	0	0	0	(309,084)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(207,096)	(92,112)	0	0	0	0	0	0	0	0	0	(299,208)	29

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Christian Homes, Inc	100.00%	\$ 12,669	\$ 12,669 1
2	V	6 Maintenance				13,767	13,767 2
3	V	17 Administrative	396,180			93,426	(302,754) 3
4	V	19 Professional Services				11,190	11,190 4
5	V	21 Clerical				119,872	119,872 5
6	V	22 Employee Benefits				36,401	36,401 6
7	V	24 Travel & Seminar				15,266	15,266 7
8	V	26 Insurance				1,477	1,477 8
9	V	30 Depreciation				22,244	22,244 9
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 396,180			\$ 326,312	\$ * (69,868) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2003 Ending: June 30, 2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	This workpaper is not applicable.					Hours	Percent	Description	Amount		1
2									\$		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Havens Christian Home # 0018143 Report Period Beginning: July 1, 2003 Ending: ne 30, 2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	This workpaper is not applicable.				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	1993-A GR Bond	x		Debt restructure	\$3,110.63	01/01/93	\$ 420,000	\$ 330,225	01/01/18	0.0650	\$ 21,659	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,110.63		\$ 420,000	\$ 330,225			\$ 21,659	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 420,000	\$ 330,225			\$ 21,659	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Fair Havens Christian Home**# **0018143** Report Period Beginning: **July 1, 2003** Ending: **June 30, 2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	8	
	2000	9	
	2001	10	
	2002	11	
	2003	12	
			FOR OHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fair Havens Christian Home COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0018143

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-12-21-428-011</u>	<u>21-16-2 Mueller's 3rd RSVY</u>	\$ <u>343.46</u>	\$ _____
2. <u>07-07-15-451-006</u>	<u>Hickory Point Christian Village Lot 1</u>	\$ <u>2,956.32</u>	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>3,299.78</u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 56,500

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	57,000	1972	\$ 54,638	1
2	Home Office Allocation			9,626	2
3	TOTALS	57,000		\$ 64,264	3

Facility Name & ID Number Fair Havens Christian Home

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Report Period Beginning:

July 1, 2003 Ending: June 30, 2004

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1977	1977	\$ 2,180,767	\$ 51,312	40	\$ 54,519	\$ 3,207	\$ 1,454,242	4
5					384,841		20	19,242	19,242		5
6	6		1983	1983	109,815	2,745	35	3,138	393	56,273	6
7											7
8		Home Office Allocation			76,577	2,219		2,219		37,286	8
		Improvement Type**									
9		Wall Guards		1979	485		15			485	9
10		Garage		1979	4,167	139	30	139		3,544	10
11		Heat Tapes		1980	2,151		15			2,151	11
12		Heating System		1981	14,100		10			14,100	12
13		Wall Coverings		1981	1,277		10			1,277	13
14		Heating Control System		1982	20,503		20			20,503	14
15		Fence Guard Rail		1982	2,027		10			2,027	15
16		Electric Work		1982	2,133		10			2,133	16
17		Fire Alarm		1982	858		20			858	17
18		New Office		1983	2,700	90	30	90		1,935	18
19		Wallcovering		1983	2,301		10			2,301	19
20		Tiling		1983	615		10			615	20
21		Office Remodel		1984	2,594	86	30	86		1,756	21
22		Window Installation		1984	2,083		10			2,083	22
23		Down Spouts		1984	639		10			639	23
24		Floor Covering		1984	550		10			550	24
25		Roof Work		1984	163,201	4,080	40	4,080		87,123	25
26		Electric Door		1984	10,229		10			10,229	26
27		Floor Covering		1985	3,457		10			3,457	27
28		Fire Alarm		1985	1,705	85	20	85		1,651	28
29		Windows		1985	3,558		10			3,558	29
30		Roof		1985	29,843		15			29,843	30
31		Door Kick Guards		1985	419		10			419	31
32		Electrical Recepticals		1986	2,419	121	20	121		2,198	32
33		Wiring		1987	7,530	376	20	376		6,547	33
34		Ceiling		1987	300		10			300	34
35		Rewiring		1987	1,600	80	20	80		1,333	35
36		Wallpapering		1989	505		5			505	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

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Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Signs	1989	\$ 1,224	\$	5	\$	\$	\$ 1,224		37
38	Soap Dispensers	1989	672		5			672		38
39	Compressor Freezer	1989	810		5			810		39
40	Storage Cabinet	1990	1,100	73	15	73		1,052		40
41	Tempering Valve	1990	3,199	213	15	213		3,053		41
42	Remodel Dining Room	1991	4,708	235	20	235		3,290		42
43	Install Panic Bars	1991	780		10			780		43
44	Install Window	1991	988	66	15	66		875		44
45	Flooring	1991	4,380		5			4,380		45
46	Roof Repair	1991	29,860	1,991	15	1,991		26,215		46
47	A/C Compressor	1991	1,076		5			1,076		47
48	Touchpads Exit Door	1991	792		10			792		48
49	Stainless Steel Sink	1991	1,630		10			1,630		49
50	Walkway Canopy	1991	4,412	221	20	221		2,818		50
51	Showers	1991	3,669		10			3,669		51
52	Remodel Office	1992	8,715	436	20	436		5,268		52
53	Door Locks & Magnets	1992	2,540		10			2,540		53
54	Interior Landscaping	1992	3,839		10			3,839		54
55	Handrails	1993	12,800	853	15	853		9,810		55
56	Wall Cabinets	1993	2,564	171	15	171		1,938		56
57	Bathroom Remodel	1993	12,341	617	20	617		6,890		57
58	Nurses Station Desks	1994	18,588	929	20	929		9,677		58
59	Alarm/Auto Door	1994	4,257	317	10	317		4,257		59
60	Cabinets	1994	1,480	99	15	99		998		60
61	Carpeting in Office	1993	979		5			979		61
62	Gas Rooftop Piping	1994	4,905	245	20	245		2,389		62
63	Heating & A/C Unit	1994	5,565	278	20	278		2,711		63
64	Remodel Garage	1995	3,704	370	10	370		3,484		64
65	Remodel Nurses Station	1995	15,656	1,566	10	1,566		14,355		65
66	Thru Wall A/C Unit	1995	3,120		8			3,120		66
67	Flourescent Light Covers	1995	1,218		5			1,218		67
68	Roof Work	1995	52,000	3,467	15	3,467		31,492		68
69	Service Sink	1995	1,003	100	10	100		917		69
70	TOTAL (lines 4 thru 69)		\$ 3,250,523	\$ 73,580		\$ 96,422	\$ 22,842	\$ 1,910,139		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,250,523	\$ 73,580		\$ 96,422	\$ 22,842	\$ 1,910,139	1
2	Wallcovering Dayroom Station 1	1995	2,573		5			2,573	2
3	Baseboard Pipe	1995	2,978		5			2,978	3
4	Thru Wall A/C	1995	3,120	65	8	65		3,120	4
5	Shower Valves	1995	1,807	181	10	181		1,584	5
6	Resident Room Signs	1995	1,516		5			1,516	6
7	Utility Room Cabinet	1995	599	40	15	40		350	7
8	Magnets for Fire Doors	1995	795		5			795	8
9	Fire Door Closers	1995	1,200		5			1,200	9
10	Install 2 Deck Faucets	1995	826		5			826	10
11	Blank								11
12	Install Sprinkler Laundry	1995	557	56	10	56		485	12
13	Electronic Thermostats	1995	733		5			733	13
14	Breakers 6/receptacles	1995	883		5			883	14
15	Remodel Main Lobby	1995	4,569		5			4,569	15
16	Remodel Station	1996	12,472		5			12,472	16
17	Rooftop Heating/AC Dining Room	1996	11,975	1,198	10	1,198		10,183	17
18	Floorwork Dayroom	1996	2,247		5			2,247	18
19	Heating & A/C Station	1996	7,550	755	10	755		6,355	19
20	Floorwork Dining Room	1996	6,974	697	10	697		5,866	20
21	Water Softener	1996	10,580	1,058	10	1,058		8,640	21
22	2 Sprinkler Cooler	1996	772		5			772	22
23	Remodel Station	1996	8,261		5			8,261	23
24	Shelving Linen Closet	1997	540		5			540	24
25	Gas Piping in Laundry	1997	1,155	116	10	116		841	25
26	Heating & A/C Rooftop	1997	8,950	895	10	895		6,414	26
27	Floorwork Station 4 Hall	1997	10,153	1,015	10	1,015		7,190	27
28	Dining Room Announcement	1997	549		5			549	28
29	Remodel Beauty Shop	1997	1,370		5			1,370	29
30	Energy Management System	1997	14,637	732	20	732		4,880	30
31	Remove Slab Freezer Area	1997	2,860		3			2,860	31
32	Floor Tile - Station 4 Rooms	1998	7,500		5			7,500	32
33	Station 3 Carrier FR A/C	1998	7,597	760	10	760		4,623	33
34	TOTAL (lines 1 thru 33)		\$ 3,388,821	\$ 81,148		\$ 103,990	\$ 22,842	\$ 2,023,314	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning:

July 1, 2003 Ending: June 30, 2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,388,821	\$ 81,148		\$ 103,990	\$ 22,842	\$ 2,023,314	1
2	Carpet Chapel/Lobby/Office	1998	2,483		5			2,483	2
3	Wood Cove BS/60 Rooms	1998	9,412		5			9,412	3
4	Alarm System	1998	11,937	1,194	10	1,194		7,258	4
5	Wallpaper Station 1 & 2 Rooms	1998	38,443		5			38,443	5
6	Ventilation - Electric Room	1999	1,875	94	5	94		1,875	6
7	48-Safety Grab Bars	1999	864	57	5	57		864	7
8	161-Glass/Resident Walls	1999	2,256	226	10	226		1,281	8
9	Install Grab Bars	1999	2,401	240	10	240		1,320	9
10	Install 24V Door Closer	1999	1,189	118	5	118		1,189	10
11	Water Heater - Station 3	1999	655	98	5	98		655	11
12	Remodel Station 4	1999	26,585	1,772	15	1,772		9,295	12
13	Back Door Alarm Pad	1999	2,874	287	10	287		1,507	13
14	Nurse Call Units	1999	598	60	10	60		310	14
15	Front Countertop	1999	881	59	15	59		305	15
16	Mixing Valve/Install	1999	524	95	5	95		524	16
17	Pella Storm Window - 13	1999	527	98	5	98		527	17
18	Smoke Detectors-4	1999	553	55	10	55		280	18
19	Carrier Rooftop Unit	1999	6,779	678	10	678		3,446	19
20	Wallpaper Station 3 Rooms	1999	23,706	4,358	5	4,358		23,706	20
21	Compressors (3)	2000	2,239		3			2,239	21
22	Cove Base-Station 3	2000	1,408	282	5	282		1,363	22
23	Baseboard	2000	1,371	274	5	274		1,302	23
24	Light Fixtures (2 Day Room)	2000	947	95	10	95		451	24
25	Floor Tile-Hall/Bath/Kitchen	2000	3,079	616	5	616		2,875	25
26	Panic	2000	1,059	212	5	212		936	26
27	Security Locks-Front Door	2000	900	180	5	180		765	27
28	Exhaust Fans (6)	2000	702	140	5	140		595	28
29	Carrier Rooftop Unit	2000	7,637	764	10	764		3,183	29
30	Ceiling Grid Covers	2000	1,418	177	8	177		723	30
31	Compressor Room 101	2000	1,131	75	15	75		306	31
32	REMODELING FHCH	2000	6,395	640	10	640		2,507	32
33	REMODELING PROJECT	2000	7,075	708	10	708		2,537	33
34	TOTAL (lines 1 thru 33)		\$ 3,558,724	\$ 94,800		\$ 117,642	\$ 22,842	\$ 2,147,776	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,558,724	\$ 94,800		\$ 117,642	\$ 22,842	\$ 2,147,776	1
2	(2) BOILERS INSTALLED W/ EMERG LIGHTS	2001	20,942	2,094	10	2,094		6,457	2
3	Roof Top A/C Unit	7/2/2001	1,295	130	10	130		390	3
4	(2) BOILERS INSTALLED W/ EMERG LIGHTS	7/15/2001	782	78	10	78		234	4
5	Compressor - Dining Room A/C	10/6/2001	646	215	3	215		591	5
6	Replace (8) Fire Alarm-A/C Relays	4/17/2002	1,519	506	3	506		1,139	6
7	Heating & Cooling System - Office	6/14/2002	2,275	228	10	228		475	7
8	Locks (3) for Fire Doors	6/15/2002	4,077	408	10	408		850	8
9	2-Compressors-Station One Day Room	7/12/2002	1,128	376	3	376		752	9
10	Tile Work-Kitchen, Mechanical Room & 7D	8/14/2002	5,580	279	20	279		535	10
11	Water Cooler-Station #1	9/6/2002	715	143	5	143		262	11
12	(22) Carrier through the wall A/C units	9/1/2002	28,380	3,548	8	3,548		6,505	12
13	Floor Covering/Cove Base - 11 Baths	9/18/2002	3,960	792	5	792		1,452	13
14	(2) Exit doors & Installation	11/21/2002	2,718	136	20	136		227	14
15	Reroof Garage	1/8/2003	1,665	278	6	278		417	15
16	(36) Bathroom Grab Bars-Stats	1/19/2003	7,677	768	10	768		1,152	16
17	Install New Circuit for Food Well	3/22/2003	511	102	5	102		136	17
18	Install New Locks on all doors	5/1/2003	2,550	255	10	255		298	18
19	Fire Alarm Door Closure/Holder	6/24/2003	895	90	10	90		98	19
20	Roof Top A/C Unit	6/30/2003	5,090	509	10	509		551	20
21	Security System/Camera/Cable/Cabinet (DISPOSED)	7/15/2003	17,361	1,736	10	1,736		1,736	21
22	Data/Phone Lines - Cabling	7/17/2003	12,404	1,240	10	1,240		1,240	22
23	Replace Staff Dr A/C Compressor	7/17/2003	711	237	3	237		237	23
24	Hand sinks in resident rooms	8/13/2003	1,428	131	10	131		131	24
25	Additional Smoke Alarms on Fire System	9/11/2003	1,337	112	10	112		112	25
26	New Partitions in Front Restrooms	10/29/2003	2,794	209	10	209		209	26
27	Electrical Updates - Breakers/Panel	11/14/2003	31,417	1,047	20	1,047		1,047	27
28	Plans & Specs-Delayed Egress Locks	11/25/2003	2,571	129	10	129		129	28
29	Installation Panic Bar on Front Door	9/19/2003	735	123	5	123		123	29
30	High Efficiency Ballasts and Lights	12/11/2003	49,970	2,915	10	2,915		2,915	30
31	Replace Breakers	1/12/2004	5,962	149	20	149		149	31
32	10x12 Canopy Bldg	1/28/2004	1,500	63	10	63		63	32
33	Delayed Egress Locking System	1/21/2004	10,945	456	10	456		456	33
34	TOTAL (lines 1 thru 33)		\$ 3,790,264	\$ 114,282		\$ 137,124	\$ 22,842	\$ 2,178,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,790,264	\$ 114,282		\$ 137,124	\$ 22,842	\$ 2,178,844	1
2	Resurface Dishwashing Area w/Gritty Floor	2/6/2004	2,150	143	5	143		143	2
3	(12) YLLW Generator Powered Emergency	5/4/2004	518	9	10	9		9	3
4	Replace Compressor in PT Area A/C	5/19/2004	855	48	3	48		48	4
5	Delayed Egress Locking System	6/29/2004	12,373	103	10	103		103	5
6	Remodel Therapy Room w/Nurse Station	6/22/2004	8,101	68	10	68		68	6
7	Fully depreciated land improvements	10/21/1985	69,530		20			69,530	7
8	Sidewalk, landscaping, fence etc.	6/10/1992	24,404	1,221	20	1,221		17,955	8
9	Entrance sidewalk replacement	6/28/2001	7,850	786	10	786		6,328	9
10	Concrete work	5/30/2003	4,230	423	10	423		481	10
11	Storage shed	4/4/2000	1,495	150	10	150		638	11
12	New Liquid O2 Building	6/2/2003	1,995	200	10	200		217	12
13	Fire Rated Door on Oxygen Bldg	8/29/2003	1,936	178	10	178		178	13
14	Fence - Garbage Area	7/3/2003	1,596	160	10	160		160	14
15	Consult/Replace Sidewalks - NH to Parking Lot	5/20/2004	11,455	191	10	191		191	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Less: Disposals		(17,361)					(1,736)	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,921,391	\$ 117,962		\$ 140,804	\$ 22,842	\$ 2,273,157	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 592,515	\$ 76,096	\$ 76,096	\$	Various	\$ 402,694	71
72	Current Year Purchases	66,708	6,344	6,344		Various	6,344	72
73	Fully Depreciated Assets	510,167				Various	510,167	73
74	Home Office Allocation	123,058	16,387	16,387			55,589	74
75	TOTALS	\$ 1,292,448	\$ 98,827	\$ 98,827	\$		\$ 974,794	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1986 Wayne Bus	1987	\$ 30,743	\$	\$	\$	8	\$ 30,743	76
77	Patient Transportation	Van	1988	3,317				3	3,317	77
78										78
79	Home Office Allocation			14,934	3,638	3,638			9,105	79
80	TOTALS			\$ 48,994	\$ 3,638	\$ 3,638	\$		\$ 43,165	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,327,097	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,427	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,269	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,842	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,291,116	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	\$ 359,816	\$	\$	86
87	Duplex/Equipment	6,781,606	195,165	1,540,843	87
88	Forysth Land Dev. & Assist Living	690,705			88
89	Other Equip/Buildings	11,494	195	4,377	89
90	Land Improvements	660,454	37,096	275,688	90
91	TOTALS	\$ 8,504,075	\$ 232,456	\$ 1,820,908	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	This workpaper is not applicable.	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 644,760	\$	1
2	Cash-Patient Deposits	19,371		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 218,688)	914,474		3
4	Supply Inventory (priced at FIFO)	11,447		4
5	Short-Term Investments	1,355,075		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Acc Int Rec/Other A/R</u>	31,068		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,976,195	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,453		13
14	Buildings, at Historical Cost	779,516		14
15	Leasehold Improvements, at Historical Cost	10,212,075		15
16	Equipment, at Historical Cost	1,510,214		16
17	Accumulated Depreciation (book methods)	(5,010,044)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	918,717		21
22	Other Long-Term Assets (spe CIP)	690,704		22
23	Other(specify): <u>Other Assets</u>	5,614		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,521,249	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,497,444	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 437,586	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,371		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	307,218		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,650		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 765,825	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	330,225		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Apt Income</u>	1,313,217		43
44	<u>Apt & Cong Life Right & Security Dp</u>	3,804,375		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,447,817	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,213,642	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,283,802	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,497,444	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,783,552	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,783,552	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	297,839	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 297,839	17
	B. Transfers (Itemize):		
18	Transfer in from affiliate	202,411	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 202,411	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,283,802	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,528,766	1
2	Discounts and Allowances for all Levels	(1,447,836)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,080,930	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	811,519	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 811,519	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,078	13
14	Non-Patient Meals	3,537	14
15	Telephone, Television and Radio	1,051	15
16	Rental of Facility Space	2,250	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,220	19
20	Radiology and X-Ray	27,801	20
21	Other Medical Services	2,200	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 89,137	23
	D. Non-Operating Revenue		
24	Contributions	57,464	24
25	Interest and Other Investment Income***	44,589	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102,053	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) On Sale of Equip/Investments	(37,069)	28
28a	Residential/Congregate	528,501	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 491,432	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,575,071	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,227,973	31
32	Health Care	3,285,983	32
33	General Administration	1,970,232	33
	B. Capital Expense		
34	Ownership	220,469	34
	C. Ancillary Expense		
35	Special Cost Centers	484,185	35
36	Provider Participation Fee	88,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,277,232	40
41	Income before Income Taxes (line 30 minus line 40)**	297,839	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 297,839	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2003

Ending:

June 30, 2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,834	1,947	\$ 59,386	\$ 30.50	1
2	Assistant Director of Nursing	2,059	2,172	59,821	27.54	2
3	Registered Nurses	10,970	11,549	293,552	25.42	3
4	Licensed Practical Nurses	28,582	30,683	494,777	16.13	4
5	Nurse Aides & Orderlies	111,604	118,044	1,315,833	11.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,756	3,955	40,519	10.25	8
9	Activity Director	1,744	1,781	22,236	12.49	9
10	Activity Assistants	986	1,006	11,765	11.69	10
11	Social Service Workers	10,794	11,024	133,010	12.07	11
12	Dietician					12
13	Food Service Supervisor	684	803	12,710	15.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,793	27,056	245,546	9.08	15
16	Dishwashers					16
17	Maintenance Workers	3,530	3,947	68,931	17.46	17
18	Housekeepers	25,576	26,877	262,367	9.76	18
19	Laundry					19
20	Administrator	1,947	2,086	143,673	68.87	20
21	Assistant Administrator	2,869	3,075	89,050	28.96	21
22	Other Administrative	1,621	1,692	47,658	28.17	22
23	Office Manager	1,617	1,671	37,452	22.41	23
24	Clerical	5,242	5,367	85,038	15.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	2,254	2,449	25,956	10.60	33
34	TOTAL (lines 1 - 33)	242,462	257,184	\$ 3,449,280 *	\$ 13.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	396	\$ 16,852	1.3	35
36	Medical Director	52	18,000	9.3	36
37	Medical Records Consultant	12	1,440	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,812	10.3	39
40	Physical Therapy Consultant	3,968	242,300	10A.3	40
41	Occupational Therapy Consultant	3,236	197,067	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	418	27,141		43
44	Activity Consultant				44
45	Social Service Consultant	83	6,315	12.3	45
46	Other(specify) Dental	11	575	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	8,272	\$ 511,502		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Fair Havens Christian Home

0018143

Report Period Beginning: July 1, 2003

Ending: June 30, 2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
David Eversole	Administrator	0	\$ 89,050	Workers' Compensation Insurance	\$ 100,488		IDPH License Fee	\$ 2,610
Brandol West	Op. Director	0	100,508	Unemployment Compensation Insurance	14,748		Advertising: Employee Recruitment	9,934
Nancy Jones	Asst. Admin.	0	43,165	FICA Taxes	258,857		Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance	229,200		Life Services Network	7,542
				Employee Meals			NAGNA Dues	4,000
				Illinois Municipal Retirement Fund (IMRF)*			Software Support/Remote fees	6,265
				W.C. Medical Expense	53		Subscriptions	1,107
				Employee Expense	38,585		Dues	510
				Employee Physicals	8,789		Miscellaneous	988
							Less: Public Relations Expense ()	
							Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 232,723				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,956
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		\$ 687,121		
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Management Expense			\$ 396,180	Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	8,714
							Miscellaneous	3,474
							Seminar Expense	5,281
							Home Office Allocation	15,266
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 32,735
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 396,180	TOTAL		\$		
C. Professional Services								
Vendor/Payee	Type		Amount					
Van Ostrand	Legal		\$ 4,576					
Davis & Campbell	Legal		23,985					
Finn Group	Management Consultant		2,838					
Village of Forsyth	Consultant		309					
Tobin, Merritt	HR Consultant		5,850					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 37,557					

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number Fair Havens Christian Home

STATE OF ILLINOIS

0018143

Report Period Beginning: July 1, 2003

Page 23

Ending: June 30, 2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$7542
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,830 Line 3.10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 88,390
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,537
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Fair Havens Christian Home
Allocation on Benefits

6/30/2004

sms
11/3/2005

<u>Payroll Tax</u>	<u>Unemploy Contrib</u>	<u>Worker's Comp</u>	<u>Health Ins</u>	<u>Employee Comp. Med Exp</u>	<u>Employee Expense</u>	<u>Employee Uniforms</u>	<u>Employee Physicals</u>	
30,430.61	708.00	4,812.00	15,600.00		39,190.60	-605.95	8,788.90	98,924.16
5,865.56	216.00	1,500.00	4,800.00	52.68				12,434.24
19,377.86	1,392.00	9,468.00	19,600.00					49,837.86
19,788.86	1,500.00	10,212.00	19,200.00					50,700.86
169,020.99	10,044.00	68,484.00	153,600.00					401,148.99
12,457.62	768.00	5,232.00	16,400.00					34,857.62
1,915.90	120.00	780.00						2,815.90
258,857.40	14,748.00	100,488.00	229,200.00	52.68	39,190.60	-605.95	8,788.90	650,719.63

Line 3.22.3 650,719.63

Fair Haven Christian
Staffing and Salary Costs

			06/30/04		sms 11/03/05	
<u>Description</u>	<u>Line Number</u>	<u>Salary</u>	<u>% of Benefits</u>	<u>Benefits</u>	<u>Total Salary</u>	
Director of Nursing	20.1	57,072.41	2.62%	2,313.10	59,385.51	
Assist. DON	20.2	57,490.70	2.64%	2,330.05	59,820.75	
Registered Nurses	20.3	282,117.55	12.97%	11,433.98	293,551.53	
Licensed Practical Nurses	20.4	475,505.43	21.86%	19,271.82	494,777.25	
Nurses Aides & Orderlies	20.5	1,264,581.12	58.12%	51,252.38	1,315,833.50	
Rehab/Therapy Aides	20.8	38,941.33	1.79%	1,578.26	40,519.59	
Total		2,175,708.54	100.00%	88,179.59	2,263,888.13	
Benefits		88,179.59				
	<u>20.1</u>	<u>20.2</u>	<u>20.3</u>	<u>20.4</u>	<u>20.5</u>	<u>20.8</u>
	57,072.41	57,490.70	233,202.13	30,550.51	27,304.02	38,941.33
			15,143.77	376,011.23	51,613.71	
			32,697.30	33,015.28	41,856.86	
			1,074.35	35,474.26	922,783.75	
				454.15	102,559.68	
					4,425.55	
					104,998.30	
					4,202.65	
					4,836.60	
Totals	<u>57,072.41</u>	<u>57,490.70</u>	<u>282,117.55</u>	<u>475,505.43</u>	<u>1,264,581.12</u>	<u>38,941.33</u>

			hours		total from Brenda's worksheet	allocation of salary & ben total from G/L	
			worked	paid & accrued			
Pre-allocation total	20	Administrator	4,816	5,161		232,723	Pre-allocation
Allocated to:	West	Op Dir	1512		100,122	100,508	
	Jones	Asst Admin	<u>1357</u>		<u>42,999</u>	<u>43,165</u>	
Asst. Administrator			2869	3,075	143,121	143,673	Allocated
Administrator	Eversole	Admin	<u>1947</u>	<u>2,086</u>	<u>88,708</u>	<u>89,050</u>	Allocated
			4816	5,161	231,829	232,723	